MEDICAID QUESTIONNAIRE AND ASSIGNMENT

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 566 (Rev. 04-2003)

NOTICE: Medicaid has made or may make payment for services provided to you. The following information is necessary to determine if other sources of payment are available for recovery of Medicaid funds. It is the applicant or eligible client's responsibility to take reasonable measures to identify and report resources and assist the Department in obtaining information and payment from these resources. To assure continued benefits, please return this form within 30 days of receipt.

All questions must be answered in the applicable sections and your signature must be entered on the reverse side where indicated.

SECTION I - CLIENT INFORMATION

Your Full Name:	Telephone Number:	
Mailing Address: (Street)		
City:	State:	Zip Code:
Medicaid Case Number:	Medicaid ID Number:	
Other Family Members Injured:		
Date of Accident:	Injuries Received:	
Where did it occur? ☐ Work ☐ Auto ☐ Home ☐ School ☐ Other _____		
Attorney's Name: (If Applicable)		
Attorney's Address:		

SECTION II - IF VEHICLE ACCIDENT:

A. Were you ☐ Driver ☐ Passenger ☐ Pedestrian	
Owner/Driver Insurance Company:	
Policy Number:	Claim Number:
Address to send claim:	
B. Type of vehicle which struck you or the car in which you were riding: ☐ Auto ☐ Motorcycle ☐ Other _____	
Name of Driver:	Owner of Vehicle:
Address:	Address:
Telephone Number:	Telephone Number:
Insurance Company:	
Policy Number:	Claim Number:
Do you or other family member or other living in household own a vehicle? ☐ Yes ☐ No	

SECTION II - IF VEHICLE ACCIDENT (CONT)

Name of Insurance:	
Policy Number:	Claim Number:
Name of Insured:	

SECTION III - OTHER TYPE OF ACCIDENT

Location:	
Business, Homeowner or other Name:	
Name of Insurance Company:	
Policy Number:	Claim Number:

SECTION IV - WORKERS COMPENSATION:

Name of Employer:	Date of Injury:
Department of Work:	Employee Number:
Have you filed a claim for Workers Compensation? ☐ Yes ☐ No	
If yes, are you presently receiving benefits? ☐ Yes ☐ No	
If not receiving benefits, is your claim pending? ☐ Yes ☐ No	
Do you have an attorney? ☐ Yes ☐ No	
Attorney's Name:	
Attorney's Address:	Attorney's Telephone Number:
What are your specific injuries related to this accident?	
Workers Compensation Claim Number:	

MEDICAID ASSIGNMENT OF BENEFITS

In consideration of Medical Assistance rendered by the North Dakota Medicaid Program, I hereby assign to the North Dakota Department of Human Services all rights to benefits otherwise payable to me for hospital, surgical or medical services rendered to myself or any of my dependents, and I authorize payment of said benefits directly to the North Dakota Department of Human Services, the state Medicaid agency. I fully understand this assignment and acknowledge that I have an obligation to reimburse the state of North Dakota for hospital and medical expenses paid on my behalf or on the behalf of my dependents, in the event I have a right of recovery under any policy of insurance, or against any person who may be liable for the medical expenses.

Signature:	Date: